STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

STATE PLAN

GUIDELINES FOR THE REIMBURSEMENT OF COSTS FOR SERVICES TO MEDICAL ASSISTANCE RECIPIENTS FOR RURAL HEALTH CLINICS

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MISSISSIPPI TITLE XIX RURAL HEALTH CLINICS

REIMBURSEMENT PLAN

Introduction

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Mississippi Division of Medicaid (DOM) for rural health clinics (RHCs) operating in the State of Mississippi. Each clinic that has contractually agreed to participate in the Title XIX Program will adopt the procedures set forth in this Plan and those set forth by federal regulations and/or mandates.

The RHC regulations distinguish between two types of RHCs - independent and provider based. The independent RHC is a freestanding practice that is not owned or operated by a hospital, skilled nursing facility, or home health agency. The provider based RHC is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency operated with other departments of the provider under common licensure, governance and professional supervision.

Cost Reporting

Each RHC participating in the Mississippi Medicaid RHC Program will submit to the DOM two (2) copies of the Medicare cost report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) months after the close of its cost reporting year. Failure to file a cost report within five (5) months after the close of its reporting year will result in a penalty of

$50.00 per day to be imposed against the individual RHC. The year-end adopted for this plan shall be the same as for Title XVIII, if applicable. There will be no extensions of time granted for filing by the DOM. Penalties may be waived only by the Executive Director of the DOM.

An RHC that does not file a cost report within six (6) calendar months after the close of its cost reporting year may be subject to cancellation of its provider agreement at the DOM's discretion.

All RHCs are required to maintain financial and statistical records. For purposes of this plan, statistical records shall include beneficiaries' medical records. All records must be available upon demand to representatives, employees or contractors of the DOM, Mississippi Department of Audit, General Accounting Office (GAO) or the United States Department of Health and Human Services. This requirement also applies for records of related organizations as defined by 42 CFR 405.427.

The Division of Medicaid shall retain all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports.

Independent RHC cost reports are submitted on form HCFA 222, and provider based RHC costs are submitted as part of the host provider's Medicare cost report, i.e., hospitals, home health agencies, or skilled nursing facilities.

Allowable Costs

Allowable costs are those costs that result from providing covered services, are reasonable

in amount, and are necessary for the efficient delivery of those services. Allowable costs include the direct cost center component (i.e., salaries and supplies) of providing the covered services and an allocated portion of overhead (i.e., administration and facility). If a practice provides non-covered services, the costs of these services are unallowable and are excluded from the calculation of the all-inclusive reimbursement rate. In this situation, it is necessary to calculate the portion of overhead costs that should be added to the direct allowable and unallowable service costs. Allowable costs, as set forth in 42 CFR 405.2468, include: (1) compensation for services of physicians, nurse practitioners, qualified clinical psychologists, and clinical social workers employed by the clinic; (2) compensation for the duties that a supervising physician is required to perform under agreement; (3) costs of services and supplies incident to the services of a physician, nurse practitioner, qualified clinical psychologist, or clinical social worker; overhead costs and depreciation costs; and (5) costs of services purchased by the clinic.

Tests of reasonableness authorized by sections 1833(a) and 1861(v)(1)(A) of the Social Security Act may be established by Health Care Financing Administration (HCFA) or the carrier with respect to direct or indirect overall costs, costs of specific items and services, or costs of groups of items and services. Those tests include, but are not limited to, screening guidelines and payment limitations. Costs in excess of amounts established by the screening guidelines are not included unless the clinic provides reasonable justification satisfactory to the intermediary, and are used to

assess costs of services such as: compensation for the professional and supervisory services of physicians, services of physicians, as well as midlevel practitioners, and the level of administrative and general expenses. Limits on payments may be set by HCFA, on the basis of costs estimated to be reasonable for the provision of such services.

Reimbursement and Cost Settlement

The reimbursement rate for freestanding RHCs is subject to a per visit cap and the reimbursement rate for provider-based clinics is subject to the lower of costs or charges. Both rates are established by the Medicare intermediaries and are used for Medicare and Medicaid.

Reimbursement is subject to an annual reconciliation based upon comparison of actual costs determined from the provider's cost report and payments made throughout the fiscal year. For independent RHCs , this means that the calculation is based on the number of Medicaid visits and payments made to the practice during the year. Provider based RHC settlement is based on a cost-to-charge ratio for the RHC only and is not based on an aggregation of other Part B services. Settlement will never be more than 100% of charges when costs exceed charges. The cost settlement may result in an amount due to or due from the provider. Medicaid cost settlement is made only after Medicare final cost settlement is completed.

Overpayments and Underpayments

An overpayment is an amount which is paid by the DOM to a provider in excess of the amount that is proper. Overpayments must be repaid to the DOM within sixty (60) days after the date of discovery. Discovery occurs either (1) on the date the DOM first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the DOM in writing, whichever date is earlier.

Failure to repay an overpayment to the Division of Medicaid may result in sanctions as described in the following sections.

An underpayment occurs when an amount which is paid by the DOM to a provider is less than the amount that is proper. Underpayments will be reimbursed to the provider within sixty (60) days after the date of discovery.

Grounds for Imposition of Sanctions

Sanctions may be imposed by the DOM against a provider for any one or more of the following reasons:

A. Failure to disclose or make available to the DOM, or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefrom.

B. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the DOM or the Mississippi Department of Health.

C. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid claim form.

D. Documented practice of charging Medicaid recipients for services over and above that paid by the DOM.

E. Failure to correct deficiencies in provider operations after receiving written notice of the deficiencies from the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification.

F. Failure to meet standards required by State or Federal law for participation.

G. Submission of a false or fraudulent application for provider status.

H. Failure to keep and maintain auditable records as prescribed by the DOM.

I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

J. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid program.

K. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.

L. Presenting, or cause to be presented, for payment any false or fraudulent claims for services or merchandise.

M. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled (including charges in excess of the fee schedule as prescribed by the DOM or usual and customary charges as allowed under the DOM regulations).

N. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

O. Exclusion from Medicare because of fraudulent or abusive practices.

P. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.

Sanctions

The following sanctions may be invoked against providers based on the grounds specified above:

A. Suspension, reduction , or withholding of payments to a provider;

B. Suspension of participation in the Medicaid program; and/or

C. Disqualification from participation in the Medicaid program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients, their families or any other third party.

Right to a Hearing

Within thirty (30) calendar days after the date of the notice from the Director of the DOM of the intent to sanction, the provider may request a formal hearing. Such request must be in writing and must contain a statement and be accompanied by supporting documents setting forth the facts which the provider contends places him in compliance with the DOM's regulations or his defenses thereto.

Suspension or withholding of payments may continue until such a time as a final determination is made regarding the appropriateness of the claims or amounts in question.

Unless a timely and proper request for a hearing is received by the DOM from the provider, the findings of the DOM shall be considered a final and binding administrative determination.

The hearing will be conducted in accordance with the Procedures for Administrative and Fair Hearings as adopted by the DOM.

Audit Procedures

Appropriate audits, using generally accepted auditing standards, will be conducted by the Division of Medicaid or contract auditors, to verify accuracy and reasonableness of information contained in all financial and statistical reports.

The DOM will ensure that 25% of all RHCs will receive a field audit each year. The initial year that DOM will conduct audits of 25% of all RHCs will be for cost report periods ending in calendar year 1995, and each provider will receive a financial audit at least once every four (4) years. Accordingly, all RHCs will be audited at least once for cost report periods ending between January 1, 1995 and December 31, 1998. RHCs may be selected for audit based on desk review findings, random selection or the requirements of being audited at least once every four (4) years.

Included in the field audits will be cost reports, financial records, and patient records to verify that:

(1) Only allowable costs have been included in computations

(2) Costs are properly allocated to cost centers and are reasonable

(3) Visits and full-time equivalents reported are actual and agree with center medical records

All audit reports will be retained by the Division of Medicaid for five (5) years following date of completion.